NORTHUMBERLAND & DURHAM

MEDICAL SOCIETY.

SEPTEMBER 25 AND OCTOBER 9, 1884.

REPORT OF THE PROCEEDINGS

OF THE

Northumberland and Durham

MEDICAL SOCIETY.

SESSION 1884-85.

NEWCASTLE-UPON-TYNE:
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1885.

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Jonathan Hutchinson, London
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The Medical Officers of Her Majesty's Forces in the District.

NORTHUMBERLAND AND DURHAM

MEDICAL SOCIETY.

The Annual Meeting was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, September 25th, 1884—the President (Dr. Arnison) in the chair.

The following gentlemen were proposed for election :—

Charles Pope, L.R.C.P., L.R.C.S. Edin., South Shields.
Adam Robson, L.R.C.S. Edin., South Shields.
Thomas Watson, M.D. Glasg., South Stockton.
J. Coatsworth Watson, M.D. Aberd., Frederick Street, Sunderland.
James Clark Gardner, M.R.C.S. Eng., Washington.
Wm. Crump Beatley, M.D. Durh., Dispensary, Newcastle.
Wm. Turnbull, L.S.A., Gosforth.
Alfred D. Maitland, M.R.C.S., Infirmary, Sunderland.

The Secretary read the following report :—

REPORT OF THE COMMITTEE.

The Committee, on meeting the members at the commencement of another session, have once more to congratulate them upon the position of the Society, and that from a scientific, as well as from a numerical and financial point of view.

During the past year 18 new members were elected, whilst 7 resigned or left the district, and 4 were struck off for non-payment of subscriptions. At present there remains 170 names upon the list; one honorary member was elected, viz., Mr. Jonathan Hutchison, F.R.S.

The income during the year amounted to £142 17s. 8½d, including a balance of £65 7s. 8½d. brought forward from the previous year, and the expenditure to £69 0s. 9½d., leaving a balance in the hands of the treasurer of £73 16s. 11d. Again the Committee have to call the attention of members to the large number of unpaid subscriptions, no less than £23 being in arrears.

Your Committee, whilst recognising that the Society labours under a disadvantage, well nigh inseparable from large provincial medical societies, viz., a widely-scattered membership, have to express the hope that the forthcoming session may witness larger

attendances at the meetings, although they have reason to believe that the Northumberland and Durham Medical Society compares very favourably with the majority of the Medical Societies throughout the country in this respect.

Encouraged by the success which attended the discussions on special subjects during the last session (three of which were held), your Committee consider that they are warranted in recommending that three nights be set apart for special discussions during the ensuing session also, the subjects for which will be duly intimated.

The Committee recommend that a shorthand writer be engaged to report the remarks of members: this suggestion has arisen out of the difficulty experienced by the Secretary in procuring from members a copy of their remarks after the meetings, a difficulty which has led from time to time to delay in issuing the Transactions; it is hoped in this way to ensure regular publication, and at the same time to save endless trouble to the members.

During the session four excellent microscopes were purchased, at the cost of £23 1s., and it is expected that they will prove a great acquisition to the Society.

It has been resolved to try the experiment of inaugurating the session with a dinner, to be held on the night of the Annual Meeting, the opinion of members having been taken upon the subject.

The conjoint excursion was held at Staward-le-Peel in July, at the invitation of the Northumberland and Durham Medical Society, but unfortunately only a few availed themselves of it.

The report was unanimously adopted on the motion of Dr. Gowans, seconded by Dr. Eastwood.

ELECTION OF OFFICERS FOR THE ENSUING YEAR.

On the motion of Dr. Eastwood, seconded by Dr. Murphy, Drs. Anderson and Gowans were appointed scrutineers; they accordingly proceeded to count the voting papers, with the following result:—

President—S. Fielden, M.D.

Vice-Presidents—W. C. Arnison, M.D.; James Adamson, M.D.; G. B. Morgan, Esq.; G. H. Philipson, M.D.

Secretary—David Drummond, M.D.

Committee—Luke Armstrong, M.D.; T. W. Barron, M.B.; S. W. Broadbent, Esq.; Wm. Gowans, Esq.; G. H. Hume, M.D.; Walter Lyon, M.D.; James Murphy, M.D.; Thomas Oliver, M.D.; G. E. Williamson, Esq.

LIST OF PAPERS.

Dr. ADAMSON.—Osteoid cancer (or malignant osseous tumour) of the kidney.

Dr. DRUMMOND.—On a strange neurosis.

Dr. G. H. HUME.—Report of a case of gastrostomy, with remarks.

Dr. MURPHY.—1. Sequel of a case of ovariotomy. 2. Three cases of puerperal eclampsia treated with pilocarpine.

Mr. PAGE.—1. Two cases of old hernia radically cured. 2. Sequel of the case of obscure tumour of the back of the thigh simulating aneurism, shown at the October Meeting. 3. Results of amputation, treated antiseptically in the Newcastle Infirmary, from April 1st, 1878, to December 31st, 1883.

PATHOLOGICAL SPECIMENS.

Dr. ANDERSON.—1. Vesical calculi. 2. Tumour removed from the prostatic position of the bladder. 3. Malignant tumour of the tibia.

Dr. ARNISON.—Specimen of diseased tarsus.

Mr. BAUMGARTNER.—Specimen of cranial tumour.

Dr. DRUMMOND.—1. Two skull-caps, showing malignant disease. 2. Malignant disease of the liver. 3. Sarcoma of the brain. 4. Calcareous pleura.

Dr. GOWANS.—1. Compound fracture of the skull. 2. Two ovarian tumours.

Dr. HEATH.—Polypus removed from the female bladder.

Dr. HUME.—1. Prostate showing hypertrophy confined to the middle lobe. 2. Microscopical sections illustrating the pathology of rodent ulcer. 3. Tumour of the bladder.

Dr. LIMONT.—Myeloid sarcoma of of the thigh.

Mr. G. B. MORGAN.—Ovarian cyst.

Dr. MURPHY.—1. Multilocular tumour of the ovary. 2. Tongue removed for malignant disease. 3. Cancerous penis. 4. Specimen of imperforate anus. 5. Exostosis of the terminal phalanx of the great toe. 6. Trachea and larynx of a child operated upon for croup. 7. Casts from a case of imperfectly developed penis.

Dr. OLIVER.—1. Abcess of the liver. 2. Brain with cyst. 3. Tumour of the brain. 4. Malignant disease of the liver. 5. Cerebral hæmorrhage.

Mr. PAGE.—1. Uterine appendages removed by operation. 2. Urinary calculi. 3. Papilloma of the bladder.

Dr. PHILIPSON.—Specimen of anuerism of the thoracic arch, showing complete consolidation, with laminated clot.

LIST OF PATIENTS.

Mr. T. A. DODD.—A patient whose patella was excised for caries.

Dr. DRINKWATER.—1. A case of gangrene of the lung, treated by incision. 2. A girl, aged 14, on whom ovariotomy was performed.

Dr. LYON.—Case of floating kidney.

Mr. PAGE.—1. Case of excision of the tongue. 2. A man whose leg was amputated for spontaneous moist gangrene. 3. Case of tumour of the thigh, simulating aneurism. 4. Case of ununited fracture of the patella—ligature. 5. A boy on whom tracheotomy was performed for croup. 6. A case of hip disease, with cross-legged deformity. 7. A woman whose feet were affected with a strange warty disease.

DISCUSSIONS ON SPECIAL SUBJECTS.

"On the pathology of pneumonia." Introduced by Dr. Gibson.

"On the diagnosis and treatment of the injuries and diseases affecting the hip joint." Introduced by Dr. Heath.

"On the more frequent use of the forceps in midwifery." Introduced by Dr. Nesham.

NORTHUMBERLAND AND DURHAM

MEDICAL SOCIETY.

The First Monthly Meeting was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, October 9th, 1884—the retiring President (Dr. Arnison) in the chair.

Dr. Arnison said it was his duty that evening to vacate the chair in favour of the new president, his friend Dr. Fielden, who was a man in every way worthy of the position in which the Society had placed him by their unanimous vote. He was sure it was quite unnecessary to ask the members to extend to Dr. Fielden the same kindness he himself had received at their hands during his term of office.

The President (Dr. Fielden) then took the chair, and said: Dr. Arnison and gentlemen,—I beg to thank you most sincerely for the honour you have done me in electing me your president—an honour I assure you which was altogether unexpected on my part. When our late President intimated to me by letter that I was generally spoken of as his successor, I failed to discover any reason why such a distinction should be conferred upon me, and I thought then—as I do now—that it was more to do honour to the class of practitioners to which I belong than to me individually. I cannot, however, but regret, sir, that your mantle has fallen on such incompetent and inexperienced shoulders, and I accept the position with feelings of considerable diffidence; in fact I should feel utterly abashed at the task which lies before me, were it not that my acquaintance with the Society, extending now over a period of close upon five-and-twenty years, convinces me that I shall preside over a body of gentlemen who will ever be to my faults a little blind, and to whom I shall not appeal in vain for sympathy and aid if difficulty should arise. Gentlemen, this Society has grown enormously, and exercises a very important influence over the two counties from which its members are drawn, and I promise you my humble efforts shall be put forth to promote, as far as in me lies, its usefulness and prosperity.

On the motion of Dr. Luke Armstrong, a hearty vote of thanks was accorded by acclamation to Dr. Arnison for his services in the chair during the past two years. Dr. Armstrong in proposing the vote remarked that there never had been a president who had, on

retiring from the position he held so worthily, more thoroughly deserved their thanks than Dr. Arnison.

Dr. Arnison asked the members to accept his most cordial thanks for the manner in which they had received Dr. Armstrong's motion, and for the generous support he had met with on every occasion during his two years of office.

The following gentlemen were elected members of the Society:—

Charles Pope, L.R.C.P, L.R.C.S. Edin., South Shields.
Adam Robson, L.R.C.S. Edin., South Shields.
Thomas Watson, M.D. Glasg., South Stockton.
J. Coatsworth Watson, M.D. Aberd., Frederick Street, Sunderland.
James Clarke Gardner, M.R.C.S. Eng., Washington.
Wm. Crump Beatley, M.D. Durh., Dispensary, Newcastle.
Wm. Turnbull, L.S.A., Gosforth.
Alfred D. Maitland, M.R.C.S., Infirmary, Sunderland.

The following gentlemen were proposed for election:—

John Whitehouse, M.R.C.S., Park Road, Newcastle.
W. G. Ridley, M.B. Durh., M.R.C.S., Ingham Infirmary, South Shields.

Mr. HENRY F. ARMSTRONG forwarded the following:—

Return of Admissions to and Deaths at the Fever and Smallpox Hospitals from the Month of April, 1883, to September, 1884 (inclusive).

DISEASE.	1883.																								TOTAL.	
	April.		May.		June.		July.		Aug.		Sept.		Oct.		Nov.		Dec.		1884.															
																			Jan.		Feb.		March		April.		May.		June.		July.		Aug.		Sept.			
	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Scarlet Fever ...	...	...	1	...	2	...	1	...	3	...	1	...	2	...	2	...	1	...	2	...	4	...	3	...	7	...	2	...	2	...	1	...	4	1	5	...	43	1
Typhus	8	5	6	...	3	1	4	1	2	...	...	...	1	1	1	...	1	...	2	...	...	...	1	...	1	1	1	...	...	...	1	..	1	...	...	...	33	9
Enteric Fever ...	...	...	1	...	1	...	1	...	4	1	...	...	5	...	4	..	2	...	3	...	2	1	1	...	1	...	2	1	3	1	3	...	3	2	1	...	37	6
Continued do. ...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	2	...	...	1	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	3	3
Roseola	...	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...
Febricula	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	...	...	...	...	...	...	...	...	1	...
Pneumonia	...	...	...	...	...	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	...	...	...	...	...	...	1	...	2	...
Smallpox	33	5	49	7	32	4	12	4	2	1	...	...	...	...	...	...	...	...	3	...	15	1	42	2	22	5	8	1	7	...	7	...	4	...	4	...	240	30
Total	41	10	58	7	38	5	18	5	11	2	1	...	9	1	8	2	4	...	11	1	21	2	47	2	31	6	15	2	12	1	12	...	12	3	11	...	360	49

Dr. Purdie drew attention to the outbreak of typhoid fever in Gateshead. He was not able to say what the exact cause of the outbreak was. The cases were not limited to any special district, nor had they been traced to any particular milk supply. In one house he attended three individuals who were suffering from the affection, a mother and two children, and he found that the soil pipe from the water closet was united to the main drain by a common trap. They knew how imperfectly the common form of trap could prevent the sewer gas from ascending into the house.

Dr. T. W. Barron reported a serious outbreak of smallpox in the city of Durham, for which he was the Medical Officer of Health. Seventy cases had occurred during the past few months. The outbreak began about February (1884) but for the first few months was limited to a few cases. However, about two months ago it spread somewhat rapidly, so as to affect most of the districts in the city of Durham, chiefly that in which Framwellgate lay. —The speaker then gave the history of an attempt (which had not been successful) to get the Urban Sanitary Authority of the city to provide an hospital for infectious diseases.

Dr. Barron further stated that in addition to smallpox the city of Durham had been visited by typhoid fever, which he ascribed to defective water supply, and other sanitary evils, which he had from time to time endeavoured to get the Sanitary Authority to remedy, but without success.

Dr. Luke Armstrong thought it was desirable that the Society should draw up a resolution calling the attention of the proper authorities to the state of things to which Dr. Barron had referred.

Dr. McDowall drew the attention of the Society to the town of Alnwick. There the Medical Officer of Health had been unable to persuade the Local Authority to carry out his suggestions, but a man died in a lodging house under rather peculiar circumstances, which brought the death under the notice of the Coroner. An inquest was held, and the Medical Officer of Health, an Inspector of Nuisances, and other officials were examined as to the sanitary condition of the house and the immediate neighbourhood. The Coroner was so strongly impressed by the state of things that he communicated direct with the Local Government Board. An inspector was immediately sent down, and he had supported the proposals and suggestions of the Medical Officer of Health, and condemned the action of the Local Board. What would come of it if the Society put a little pressure on those small Local Boards he did not know; but he always thought it a dangerous thing to interfere between a Corporation and its officers.

After a discussion of considerable length, in which the President, Drs. Barron, Armstrong, Oliver, Murphy, and Lambert took part, Dr. Barron gave notice that he would move a resolution on the subject at the next meeting of the Society.

PATHOLOGICAL SPECIMENS.

LACERATED BRAIN.

The SECRETARY showed, in the absence of Dr. Hume, a brain taken from the body of a man who had sustained fatal injuries from falling upon his head. The skull was fractured, and the frontal lobes of the brain much lacerated.

TWO SPECIMENS OF AORTIC ANEURISM.

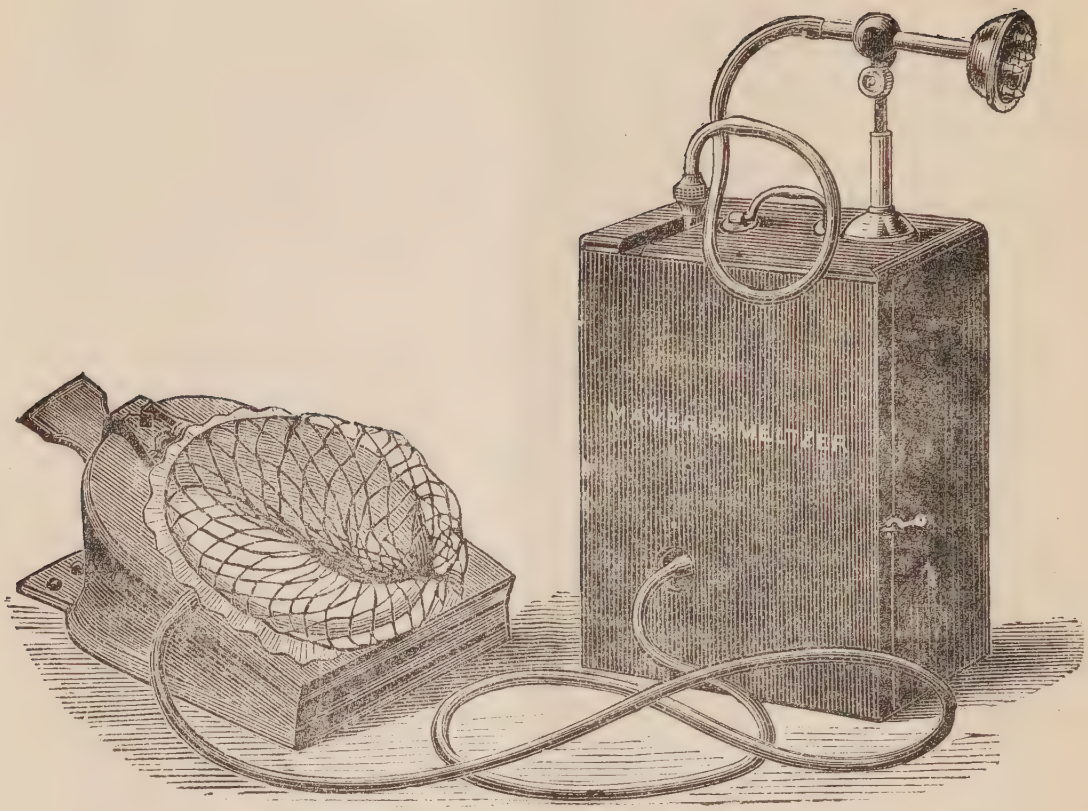
Dr. OLIVER said: The owners of these aneurisms were exhibited some time ago to the members of this Society. This aneurism was removed from the body of a man, aged 38, who was admitted under the care of Mr. Page in February, 1883. He had been a soldier for ten years—nine of which he spent in India, where he suffered from ague, on several occasions, also from syphilis. During the latter part of his life, however, he had been engaged as a *striker* in an iron factory. On admission there was seen and felt a pulsating tumour, about the size of a pigeon's egg, just above the right stemo clavicular articulation. He had pain in the chest and slight difficulty of swallowing. As there was evidence of very extensive cardiac disease, it was, at a consultation of the staff of this Infirmary, decided not to subject the patient to the operation of tying his right carotid. Accordingly, patient was transferred to the medical wards, and coming under my care, I followed out a line of treatment begun by Mr. Page, viz., rest, and the employment of large doses of pot. iodi., with restrictions in regard to diet and use of fluids. He had one or two very interesting physical signs. There was a double bruit over the aortic area, heard also over mitral area, heard too over the pulsating tumour in the neck; while over the left carotid artery, and evidently due to the compression of that artery by the trachea, which was displaced leftwards through the pressure of the tumour, there was heard only a rough loud systolic murmur. He had always a very rapid pulse. Under the use of pot. iodi., and rest in bed, patient improved. He lost his pain on swallowing, and the pain in his chest, and for a time did remarkably well. As he was in the "Reserves," he was obliged to present himself at Berwick-on-Tweed, but being under certificate he was exempted from drill, &c. He remained out of the Infirmary for nearly three weeks, during which time he discontinued the use of the medicine, and probably walked

about more than he ought to have done. At his own request he was re-admitted, and soon after died, his death being preceded by rapid emaciation. The largest dose of pot. iodi. he took was 80 grains, thrice daily which gave marked relief to all his symptoms, as already mentioned. At the *post-mortem* we found the heart very much increased in size, the left venticle particularly. The whole of the aorta enormously dilated and atheromatous, the innominate artery also extremely dilated and atheromatous; while from its inner aspect, just before it divides into right carotid and subclavian, there arose an aneurism about the size of a small egg. This aneurism formed very firm adhesions to the trachea, and dis placed it to the left, as seen in the specimen. The aortic valves were incompetent, also the mitral; the left ventricle dilated and hypertrophied, while in the interior of the ventricle were seen numerous small smooth white patches, which on microscopical examination were found to be small areas of myocarditis, and numerous leucocytes grouped together, and infiltrating themselves between the muscle-fibres. They may be syphilitic. I am inclined to regard syphilis as the main cause of the extreme and very general degeneration of the arteries in this case.—This other specimen was removed from the body of a blacksmith, aged 49, who had been under my care for more than two years. He was sent to me by Mr. Dodd in the early part of 1882. At this time he complained of pain in his left chest—a feeling of tightness there, of difficulty of breathing on exertion, of shooting pain down his left arm, and of hoarseness. There was also pain on swallowing. The right pupil was more dilated than the left; the radial pulses were equal; over the upper part of left chest there was very marked dulness on percussion. The chest here presented a distinctly rounded prominence, which pulsated. The apex beat was displaced upwards. The cardiac sounds were healthy—feeble over apex area—and the second markedly accentuated over the aortic area. Over the first and third left intercostal spaces there could be heard now and again a faint systolic murmur—never very marked, however—accompanied by a distinct sense of heaving. I at once put him upon ten grains of pot. iodi. thrice daily, and gradually increased the dose until he was taking 150 grains thrice daily. Under this method of treatment patient lost all his symptoms save the hoarseness, and the prominence in the left side of chest became flatter and ceased to pulsate. He left the hospital, but continued to take pot. iodi. in smaller doses. I saw him from time to time during the two years which followed. He enjoyed excellent health until a few months ago, when hæmoptysis set in. I saw him on one occasion, soon after he had brought up more than a pint of blood. He recovered from this, had another large hæmorrhage, and died soon after. At the *post-mortem* we found this enormous aneurism,

which had burst into the left bronchus. It occupied nearly the whole of the left chest; the left lung was compressed and firmly incorporated with the aneurism; the heart was small and healthy; the aneurism involved the whole of the arch of the aorta; its walls, which are composed for the most part of laminated clot, are several inches in thickness. I regard this case as a good illustration of the beneficial effects of the treatment of thoracic aneurism by large doses of pot. iodi.

TWO OVARIAN TUMOURS.—ANTISEPTIC AIR PRODUCER.

Dr. MURPHY exhibited two ovarium tumours which he had successfully removed, and gave a demonstration of the method of drainage employed by Dr. Heiter after ovariotomy. Dr. Murphy also exhibited Mr. Mayo Robson's "antiseptic air-producer," explained its working, and said: I am sure, gentlemen, all of you who are much engaged in antiseptic surgery would gladly welcome a substitute for the carbolic acid spray, which oftentimes seriously interferes with vision, impairs the delicacy of touch, and is generally disagreeable and unpleasant; and therefore I have much pleasure in bringing before your notice this instrument, which has been devised by Mr. Mayo Robson (of Leeds) for producing an antiseptic air, which he claims has all the antiseptic advantages of carbolic spray and none of its objectionable qualities. The instrument consists of a series of five wide metal tubes, through which air is forced by means of bellows, the first tube being filled with cotton wool, and the others with pumice stone saturated with eucalyptol. The purified and antiseptic air is distributed over the desired region by means of five coraline nozzles working on an universal joint, and as it remains invisible, does not in any way obscure the parts to be operated on, while the smell of the eucalyptol is pleasant rather than otherwise. To charge the instrument, remove the tube from the box, and unscrew the caps of the tubes containing the pumice stone, and pour on to the pumice stone about two ounces of eucalyptol, which will thoroughly saturate it; then replace the caps and the tubes, connect the bellows, and also the nozzles, and the instrument, as shown in the diagram, is in working order. Having but recently got the instrument, my experience of it is too limited to speak authoritatively on it, but in the half-dozen cases in which I have used it I have been satisfied with the results. The chief objection to it is that it requires an assistant to work the bellows. I am indebted to the courtesy of Messrs. Mayer and Meltzer, of Portland Street, London, for the block from which the accompanying plate is printed.



Dr. Gowans exhibited a new microtome invented by a patient, and showed some beautiful sections of epithelioma cut with the instrument.

AORTIC ANEURISM, SIMULATING AN ANEURISM OF THE INNOMINATE.

Dr. Drummond showed a specimen of aneurism of the thoracic aorta that simulated, during life, an aneurism of the innominate artery. The patient, a labourer, aged 42, had suffered from syphilis, was accustomed to carry heavy weights, and was a heavy drinker. His symptoms, which were principally pain in the upper part of the right chest and down the right arm, and shortness of breath, were of about twelve months' duration, The pulsating tumour had been observed in the root of the neck, some seven months before he came under observation. On admission into the Infirmary a tumour about the size of a Tangerine orange was detected above the sternal extremity of the right clavicle. This was firm to the touch and pulsated, and pushed the trachea to the left, compressing it considerably. There was dulness, and ill-defined pulsation between the cartilage of the second rib and the clavicle on the same side. The right radial was less than the left, and altogether the features of the case, so far as they could be made out, for the patient died the day after his admission into hospital, were those of an innominate aneurism. At the autopsy it was found that the sac, which was

about the size of the closed fist, took its origin not from the innominate but from the arch just behind that vessel.

ABSCESS OF LIVER AND LUNG.

Dr. DRUMMOND next showed a liver with an abcess the size of a large hen's egg. The patient from whose body the specimen has been removed was admitted into the Infirmary complaining of weakness, cough, and rigors, with profuse perspirations. He was a sailor, aged 38, and stated that he had been ill two months. He had been much exposed for some months previously on the west coast of Africa, but had escaped a virulent form of fever which had cut off twelve of the crew. His illness commenced in Algiers, and was ushered in by a fit, when he remained unconcious for an hour-and-a-half; he then vomited, and very soon afterwards the rigors commenced, which were mistaken for attacks of ague. On his admission he presented the appearance of a patient suffering from advanced phthisis. There was marked prostration and emaciation, and he complained sorely of a hacking cough, whilst on physical examination of the lungs there were ample signs of numerous cavities, especially at the back. There was no liver enlargement. The difficult point about the case, however, was the fact that he experienced rigors with drenching perspirations from time to time, which were obviously not like any of the ordinary forms of ague, though he insisted they were of that nature. He gradually grew worse, and died very much emaciated. The *post-mortem* showed that both lungs (one of which was exhibited with the liver) were riddled with cavities containing pus. These were distributed principally about the posterior and inferior regions of the pulmonary tissue, and varied in size from a small pea to a walnut. They were not surrounded by tubercular matter, and, indeed, were apparently independent of tubercle, but were, on the other hand, regarded as embolic. The liver was very slightly enlarged, but did not appear more than half-an-inch below the ribs. Its substance was healthy with the exception of the upper and posterior part of the right lobe, where a cavity about the size of a large egg was found, containing pus. Its walls were thin and comparatively smooth, and the liver substance in the neighbourhood was healthy. It would appear as though the pulmonary abcesses were the result of pus finding its way into the hepatic vein and so on into the lungs. There was no other suppuration met with in the body.

INTUSSUSCEPTION OF LARGE INTESTINE.

Dr. DRUMMOND further showed a specimen of intussusception in which the lower end of the ilium together with the cœcum had passed into the colon, forming a large tumour, which had been detected during life, in the left side of the abdomen. The patient was a woman, aged 38.

EXHIBITION OF PATIENTS.

EXCISION OF THE ULNA.

Dr. Arnison showed a young woman (with specimen) from whose right arm he had excised two-thirds of the ulna, for osteo-sarcoma of the lower end in an early stage, three months previously. The lower end was disarticulated, and the bone sawn through clear of the tumour. The wound healed readily, and the arm was very slightly altered in appearance, formation and suppuration being perfect. Dr. Arnison said he must give Dr. Drummond much of the credit of the case, as it was at his suggestion he adopted the plan of partial excision. There was no sign of return of the disease. Dr. Arnison also showed a man on whom he had operated for radical cure of a large inguinal hernia, which defied any truss to keep it in place. The result was complete retention of the gut within the belly, but the patient wore a truss for greater security. The method adopted was one brought before the British Medical Association by Mr. Fagan, of Belfast. The sac was cut down upon and cleaned from the cord ; it was then found that a piece of omentum occupied the sac and could not be got rid of, it was therefore necessary to open the sac and return the omentum. The sac was then grasped with forceps and twisted, catgut sutures were then passed through the pillars of the ring and through the twisted sac, drawing together the pillars and securing the sac between them, taking care to avoid undue pressure on the cord. The skin wound was closed by sutures and a tube left for drainage ; rapid union took place.

HEPATIC CIRRHOSIS IN A BOY.

Dr. Oliver said : This boy, who is aged 12 years, and who does not look as if he was suffering from any serious illness, was admitted under my care in November of last year. He was at this time complaining of pain in the epigastrium, and of swelling of the abdomen. He was suffering, too, from cough, and was markedly cyanotic. At this time the liver was much enlarged, not so large as at present, however, and the abdomen contained a large quantity of fluid. He was tapped on five different occasions, spread over a period of four months, and on an average five pints of fluid were removed at each operation. The spleen at this time was small. As the liver remained large and hard, a long needle was passed into it on several occasions, but we failed to draw off anything but a few drops of blood. In the month of March of this year patient caught smallpox. He was very ill. During the height of his illness the ascites entirely disappeared, only, however, to re-appear during convalescence. On his recovery he again came under my care, and under the use of pot. iodi. and liq.

hydrarg bichlor the whole of the fluid disappeared from the abdomen. It has never returned. Since then, however, the liver has gone on enlarging, and with it the spleen has gradually been getting bigger. Its lower border can now be felt. The patient is very little affected by the state of his liver and spleen ; his health is remarkably good ; he is ruddy, enjoys his meals, and never suffers from flatulence, constipation, or hæmorrhage from any of his orifices or mucous membranes. There is no swelling of feet, his urine is not albuminous. I am inclined to regard the case as one of specific cirrhosis of the liver. Dr. Oliver then explained his reasons for regarding it as such, and not ordinary cirrhosis—the so-called hypertrophic cirrhosis—hydatid cyst, or malignant disease of the liver.

Mr. Page showed a young woman with a curious warty growth in the side.

A CASE OF MALIGNANT DISEASE OF THE ŒSOPHAGUS —GASTROSTOMY—PATIENT SURVIVING OPERATION 78 DAYS.

By FREDERICK PAGE, Surgeon to the Infirmary, Newcastle-on-Tyne.

A. B., aged 46 years, a mason by occupation, was sent into the Newcastle Infirmary under my care by Dr. Besant of Cullercoats, June 5th, 1884, suffering from stricture of the gullet of some six months' standing. Patient was very much emaciated, complained of a fixed gnawing pain in the right axilla, and at the pit of the stomach, passing through to the back of the chest. He was only able to swallow, and that with great difficulty, a small quantity of milk. There was no family nor personal history from which the nature of the stricture could be inferred. The man had drank freely, and for some five months previous to his symptoms had, he said, never been sober. June 8th.—The peritoneum was exposed by means of an incision two inches in length, in the course of the fibres of the left rectus, a little to the inner side of the semilunar line, and commencing about one inch from the origin of the muscle. The belly was opened by an incision, an inch-and-half in length, when the liver, which had been plainly seen shining through the peritoneum, was exposed. The stomach was found and a portion drawn through the wound. Two silver sutures with needles at each end were passed through its serous and muscular coats, and carried through the abdominal wall from the peritoneal surface, three-quarters-of-an-inch from the margin of the skin incision. The free ends of the upper and lower sutures were now twisted together, on each side. In this way the peritoneal wound was completely plugged by the retained stomach. There was no crevice at either the upper or lower extremity of the peritoneal incision, and no muscular fibres being cut across, there was no tendency for the wound to be opened by any action of the abdominal muscles, as is the case with the ordinary incision; indeed, coughing closed the wound so completely as to entirely conceal any portion of the stomach. The operation was not followed by vomiting, or constitutional disturbance. A piece of Indian-rubber tubing was introduced through a small opening into the stomach, retained by means of a safety-pin, and plugged with a piece of wood. The wound healed readily, and a very perfect fistula was formed, by means of which fluid food was given at short intervals. The skin around the fistula was never excoriated. For some weeks the patient steadily improved, his pain was relieved, he gained flesh and strength, and at times was able to swallow even as much as a round of bread at a meal. But his pain and inability to swallow returned, and occasionally he vomited small quantities of blood. July 21st.—He vomited 12 ounces of blood.

From this time he was fed entirely by the tube, and required frequent hypodermic injections of morphia. On August 25th he died, 78 days after the operation, reduced almost to a skeleton, and having acquired thoroughly the aspect of a man suffering from malignant disease.

I am indebted to Mr. Baigent for the following description of the very carefully-prepared specimen, which his industry and skill also enable me to show you here this evening.

The œsophagus is nine-and-a-half inches in length, and the stricture, which will admit a penholder, is situated seven-and-a-half inches from its upper end. In process of removal, its posterior wall has been torn immediately below the point of obstruction. Above the stricture the walls of the canal are much thickened, while below they are thinned. The right pneumogastric gives off some large branches to a number of hard black bronchial glands, which are as big as walnuts. Many similar glands, a portion of the left bronchus, and the aorta are bound together and firmly attached to the left side of the œsophagus. To the right side a small piece of lung is adherent. The stomach is small and contracted. The fistula enters the anterior surface at a point just midway between the pyloric and cardiac orifices. There is sound and perfect union between the opposing peritoneal surfaces, and a piece of the liver is adherent to the abdominal wall at the site of junction. Secondary deposits occur between the liver and stomach and the pancreas and stomach. Upon opening the stomach, an extensive mass of malignant disease is seen to surround the cardiac orifice. This is found to be continuous, with disease of the same character at the lower end of the œsophagus, giving rise to the stricture already mentioned.

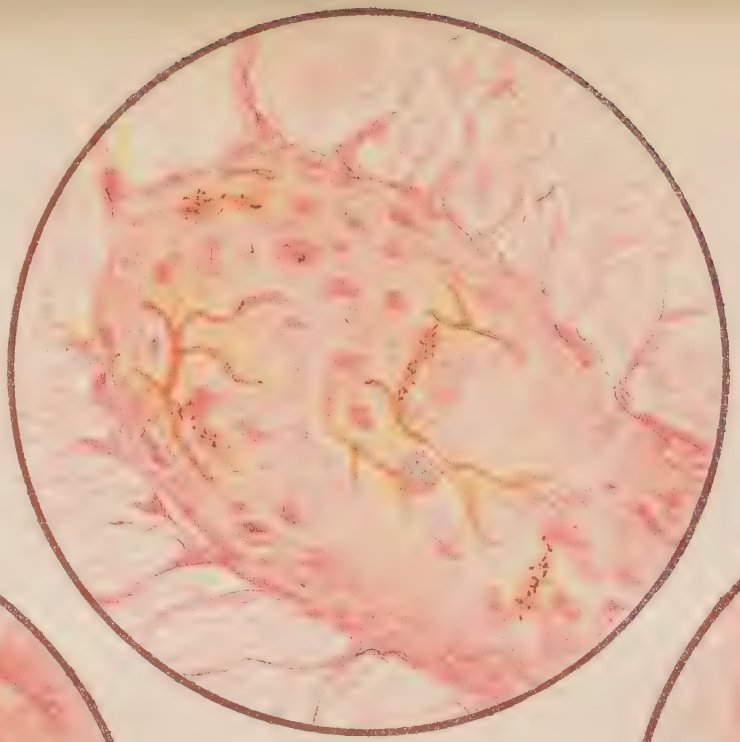
My experience of gastrostomy is very limited. I have performed the operation thrice, and seen it performed by my colleagues other three times. All the patients suffered from malignant disease of the œsophagus. The method of operating has in all, but the case I am now reporting, been that recommended by Mr. Howse. I ventured to depart from the ordinary incision in this case, and am encouraged by the result to adopt the same plan of reaching and securing the stomach on any future occasion I may find it desirable to establish a gastric fistula. Of the six cases I have alluded to, five terminated fatally a few days after operation from congestion of the lungs.

Life in this instance was undoubtedly prolonged, and, the patient frequently said, rendered more comfortable, by gastrostomy. I am not aware that any patient suffering from malignant disease has survived the formation of a gastric fistula for a longer time than 78 days, and I think the result of this case a sufficient justification as to the propriety of operating for malignant disease, provided the condition of the patient is not such as to make the operation itself a fatal procedure.

ON THE NATURE OF THE SPINAL LESION IN POLIOMYELITIS ANTERIOR ACUTA, OR INFANTILE PARALYSIS.

By DAVID DRUMMOND, M.A., M.D., Physician to the Infirmary, and Children's Hospital, Newcastle-on-Tyne.

It is the opinion of wellnigh all pathologists that the paralysis and atrophy so typical of this disease are the result of destructon of the ganglionic cells in the anterior grey cornua. This is the position taken up by nearly all clinical and pathological teachers, without any fear of contradiction; and, indeed, the numerous *post-mortem* examinations made in cases where death has resulted from some independent affection some time after the onset of the lesion, have proved its truth. It has, however, fallen to the lot of very few to examine the cord of a child very soon after it has become affected, in what might be called the acute or inflammatory stage, for, as is well known, it is a lesion that very rarely proves fatal; consequently the exact nature of the essential and primary lesion is little more than a matter of conjecture. Such a chance has recently occurred to me—for which opportunity I am indebted to my friend Dr. Pope of South Shields. The child whose spinal lesion I am about to describe was a girl, aged five. At breakfast-time of the day of her death she was in her usual health, but shortly after her meal she felt sick and vomited. She was then put to bed, when she slept for several hours. Early in the afternoon it was observed that she was feverish and evidently in a dying condition, an observation that was soon consummated, as her death took place six or seven hours after the commencement of her illness—the result, as was afterwards surmised, of respiratory paralysis. At Dr. Pope's request I made a *post-mortem* examination. The body was well nourished. The heart was healthy. The lungs were somewhat congested, and in the left was found a small nodule of catarrhal pneumonia, about the size of a walnut. The abdominal cavity and its organs were normal. The brain appeared to be healthy in every respect. Failing to account for death by the changes noted in the lungs, which, so far, were the only morbid conditions detected, I proceeded to examine the upper part of the spinal cord, when I observed, as it was divided transversely at various levels from the medulla oblongata downwards, that the grey anterior horns appeared altered between the third and fourth cervical nerves; whilst at the level of the latter there was a distinct area which suggested *red softening*. This portion of the cord was hardened in a solution of bichromate of ammonium, cut with an ice-freezing microtome, and stained with carmine.



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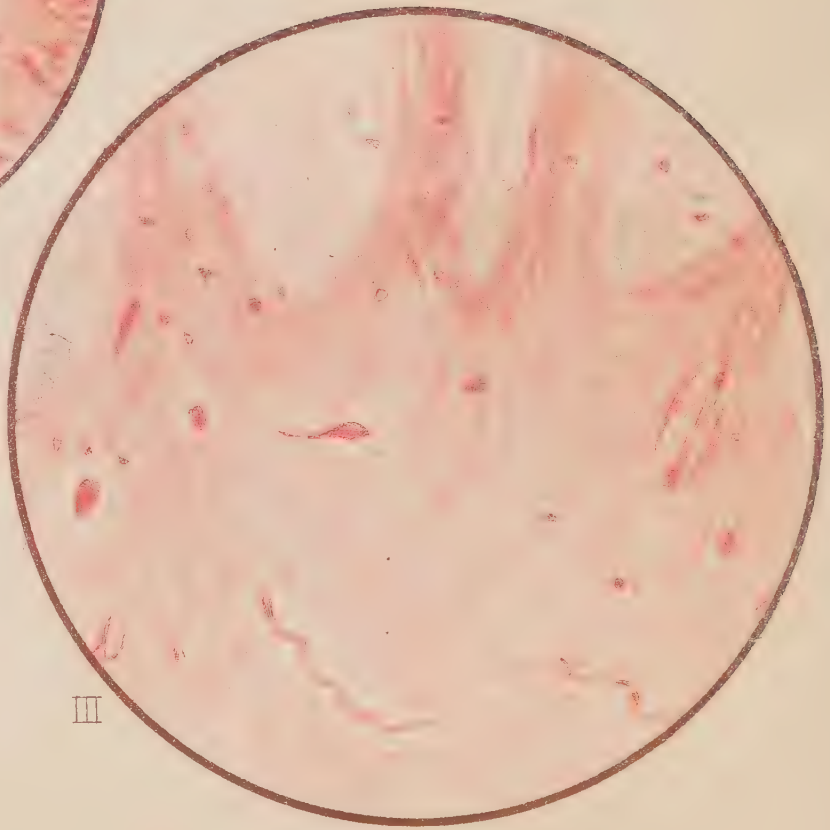

III

TO ILLUSTRATE DR. DRUMMOND'S PAPER ON "THE PATHOLOGY OF INFANTILE PARALYSIS."

When examined by the low power of the microscope (half-inch), fig. I.,* the extreme vascularity of the anterior horns was at once apparent. In some of the sections, in addition to the unusual display of capillaries, minute patches of yellow figured prominently upon the carmine groundwork. The ganglionic cells were seen to be numerous and distinct, though apparently swollen. With the high power ($\frac{1}{6}$ inch), fig. II., the blood-vessels, distended with corpuscles, formed a striking feature, not only of the anterior horns, but of the anterior white columns and middle and anterior portions of the posterior horns as well, for the inflammatory mischief was by no means confined to the first-named region. Following the tracks of the arteries (internal and external anterior root arteries, and the antero-lateral branch) as they made their way from the front of the periphery of the cord, through the white matter, to enter the anterior horns, minute hæmorrhages were scattered here and there, whilst congestion, with free leucocytes, was apparent. In places the neuroglia was swollen and so altered as to obliterate in part the meshy character of the structure, and thus conceal the cut ends of the axis cylinders. In this way the bulk of the anterior columns formed a marked contrast to the beautiful and distinct arrangement of neurogliar network, with the nerve fibres seen as central dots, which marked the postero-lateral columns. As the anterior grey horn was approached, the signs of inflammation increased, attaining a maximum as the swollen and somewhat ill-defined mass of grey matter was reached. Here the dilated vessels were crammed full of corpuscles, whilst the capillary network was rendered most distinct, each vessel containing its single or double row of cells. The minute hæmorrhages, which were seen as collections of yellow-coloured blood cells, formed the most striking feature of each field that was examined. These extended as far back as the distribution of the posterior branches of the central artery on each side, that is, quite into the posterior horns, but they were most numerous in the anterior cornu, about the ganglionic cells. The large cells formed prominent objects, though they were apparently swollen, granular, and rather ill-defined; and it was observed that the majority had lost their nuclei, though here and there a ganglionic cell with a nucleus could be distinguished. Their processes were no longer visible, and they appeared to fill completely the spaces in which they lay. The cells that presented the most obvious changes were more or less surrounded with dilated and blocked capillaries and minute hæmorrhages; some, indeed, appeared to be imbedded in blood corpuscles.

In most of the sections it was apparent that one horn had suffered more than its fellow, though in most of those examined

* These drawings are by Mr. Chas. Steenberg, Student of Medicine, to whose kindness and artistic skill I am greatly indebted.

both horns showed inflammatory changes. The grey fibres which form the bulk of the anterior horns were swollen and obscure, the whole presenting an indefinite and somewhat granular appearance, which contrasted strangely with the uninjured portions of the posterior horns and roots.

The pronounced changes above described were only observed in a very limited portion of the spinal cord, for as the sections gradually ascended or descended from the affected area, a return to the normal state was brought to light, the signs of inflammation diminishing in intensity until, and that even in the immediate neighbourhood, a few isolated hæmorrhages with distended capillaries alone were found.

Although the accident of the situation of the lesion, attacking as it did the region of the origin of the phrenic nerve, prevented the little patient from living long enough after the onset of the inflammation to admit of an exact clinical diagnosis, I do not imagine that anyone will be found to question the identity of her case with *polio-myelitis anterior acuta*, and I make no apology for the assumption that they are the same. I think, therefore, the case is one of considerable importance, as demonstrating the early changes that lead up to the later degenerations which all are so familiar with in old-standing cases of infantile paralysis. Fig. III., added to the illustration for comparison, is from a pronounced case of some years standing, and shows very plainly some of the results of the inflammatory attack—notably the fact that the large ganglionic cells in the anterior cornu have disappeared entirely or in part, and have lost their polar attachments.

In the year 1870, Dr. Clifford Allbutt recorded in the *Lancet** a case which has been frequently quoted by writers on infantile paralysis (Ross and others), and I think erroneously, as an example of the disease. In this case an examination of the cord, soon after the occurrence of the lesion, revealed two hæmorrhages in the cervical region, "one a small one in the left posterior horn, and the other larger, in the right posterior horn, breaking into the lateral column." I do not think this case can be fairly regarded as a true example of *infantile spinal palsy*, as Dr. Allbutt points out that the paralysis, which affected all four extremities, came on a few minutes after the child, aged six months, had been lifted sharply, when its head fell heavily forward. Obviously there is here an element of traumatism foreign to most cases of acute anterior polio-myelitis of infants; and, further, the hæmorrhages appeared to be confined to the posterior half of the cord, a region which, though affected in the case I have described, and also in one to which I am about to refer, recorded by Dr. Angel Money,

* *Lancet*, 1870, Vol. 2, p. 84.

cannot be looked upon as the real seat of the disease. I am, therefore, disposed, with all due deference to Dr. Allbutt and those who, in quoting the record, have shared his opinion, to think that the hæmorrhages in the case were the result of injury rather than inflammation.

In the transactions of the Pathological Society of London for 1884 (just published),* page 45, Dr. Angel Money describes under the title, "The Spinal Cord of a recent and old case of Infantile Palsy," the appearances of the cord of a child, aged two years, who died of pulmonary disease sixteen weeks after the onset of an attack of acute anterior polio-myelitis. The changes found in the lumbar enlargement were "(1) great distension and thrombosis of vessels, especially in the anterior cornua; (2) infiltration of the cornua with abundant leucocytes; (3) absence of large multipolar or other nerve cells." Dr. Angel Money goes on to state as follows:—"Further, it was seen that the disease was not confined to the anterior horns, but spread forwards, outwards, and backwards; though the principal focus of the mischief was certainly the centre of the anterior horn." This observation, published some time after I had written the above short account of the spinal cord in Dr. Pope's case, confirms my own, in so far as it shows that the inflammation is not by any means confined to the large ganglionic cells, or even to the anterior horns; but the fact that it was made sixteen weeks subsequent to the attack, is sufficient to explain the apparent slight differences between Dr. Money's description and my own of the primary lesion.

Althaus states in his essay on infantile paralysis, to which the silver medal of the Medical Society of London was awarded, March 8th, 1878, and I believe him to be correct, that there were at that date no *post-mortem* records where the child had not been paralysed for at least two months, nor am I aware that any more recent examinations have been made since he wrote. The case I have recorded would appear to set at rest the question discussed by Charcot, Roth, Dujardin, and others, namely, whether the inflammation is parenchymatous or interstitial, for it is obvious that the several parts affected—the neuroglia, the nerve fibres, and the ganglionic cells—must take part, though they may not all share alike, in the destructive processes induced by the inflammation. Indeed, the brunt would appear to fall on the large cells, a fact revealed alike by the examinations of old-standing cases, and the clinical features of the disease.

Reference has already been made to the extension of the inflammation beyond the limits prescribed by the various writers on the subject, for it will be recollected that though the fresh changes

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* I am indebted to Dr. Allbutt for this reference.

were found most abundantly in the anterior horns, they, nevertheless, affected the antero-lateral white columns, and part of the posterior horns as well; in fact, the anterior cornua were only the centres of inflamed areas, which reached considerably beyond their limits. It will, therefore, become a question whether the name proposed by Kussmaul, and adopted by the majority of writers—anterior polio-myelitis—is really an appropriate one, though usage in the nomenclature of disease, as in other matters, will be found to resent interference.

In conclusion, I would like to point out two ways in which the recognition of the real nature of the primary lesion of infantile paralysis is of importance. In the first place, it throws light upon the attacks of *temporary spinal paralysis of infants*—seizures, if I may be allowed the expression, which I confess have puzzled me not a little. An example, briefly related, may not be out of place. A little boy, aged 16 months, whilst cutting his eye-teeth, was observed one day to be unusually peevish when being dressed to go into the garden in his perambulator. As he continued to fret, his nurse attempted to amuse him by offering him a ball, when she discovered that he could not raise the left arm to seize it. He was at once taken into the house and undressed, in order to discover if the arm had been injured, when it was found that he was feverish, and that the left arm was very hot and painful (hyperæsthetic.) There was no bruising or other evidence of injury, but the limb hung down completely paralysed. When asked to clap his hands, an accomplishment which he had acquired some time before, he contented himself with slapping his right hand against his leg, ignoring the left entirely. The paralysis lasted for 24 hours, and recovery of motion, which was apparently accelerated by the application of cold to the limb, was first observed in the fingers.

It will not be difficult to explain such an attack by the supposition that a limited area of the left anterior horn in the cervical enlargement had suddenly become congested, the lesion stopping short of actual inflammation.

In the next place, the necessity for early energetic antiphlogistic treatment is emphasized, in order to overcome the inflammation, or reduce it as much as possible, by rest, cold to the spine and affected limb, leeches, or, as recommended by Althaus, the hypodermic injection of ergotin; and the fact that some attacks are only temporary, whilst in others, and indeed nearly all, there is a tendency to recovery shown by some of the muscles at first paralysed, should stimulate us to endeavour to recognize the condition as early as possible, and to carry out thoroughly the curative means at our disposal.

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